Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 29, 2018

Ms. Brenda Schill, Manager
Our Lady Of Providence
47 West Spring Street
Winooski, VT 05404-1397

Dear Ms. Schill:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 11, 2018.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0198	A. BUILDING _____ B. WING _____	C 04/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

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R100	Initial Comments: An unannounced on-site re-licensure survey was completed by the Vermont Division of Licensing and Protection on 4/11/18. The survey also included investigation of a complaint related to resident care and safety. The following regulatory violations are related to the re-licensure survey and the complaint investigation.	R100	See attached	
R126 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide necessary services related to the resident's psychosocial, nursing and medical needs for 1 of 5 residents in the total sample. (Resident #1). Findings include: 1. Subsequent to a complaint received by the Licensing Agency related to a resident's death after an accident involving mechanical lift equipment, an on-site investigation was completed on 4/11/18 and regulatory violations related to nursing care were confirmed. Per record reviews, Resident #1 fell from a Hoyer lift when one of the upper body sling loops became disconnected from the Hoyer hook. Two LNAs (Licensed Nursing Assistants) were transferring	R126	See attached See attached POC's accepted 5/17/18 M. Bolton RN / S. Remy RN See attachments for accepted POC's.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brenda Schell, Administrator
May 10, 2018

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R126	Continued From page 1 the resident from the bed to a wheelchair at the time of the accident. The care plan for Activities of Daily Living (ADLs) stated that the resident was totally dependent on staff for all ADLs and required a Hoyer lift with assist of 2 staff for all transfers. The accident happened on 3/15/18 at 10:30 AM per review of the event report and the nursing progress notes. LNA #1 was operating the battery operated Hoyer lift on the window side of the bed; LNA #2 was standing on the wall side of the bed. Each LNA had to attach upper and lower body sling loops to the appropriate hooks on the support bar of the Hoyer. As the resident was being turned to the window side of the bed (while in the lift), LNA #2 pushed the resident 's legs towards the window and failed to follow procedure and come around the bed and support and guide the resident in the lift, per procedure. When the lift was in position near the edge of the bed, the blue loop strap (supporting the left upper body), came off of the Hoyer hook and dropped down, allowing the resident to fall out of the sling. The nurse's progress note of the incident dated 3/15/18 at 11:20 AM, stated "Witnessed fall from Hoyer lift with two person assist. Res. fell out of sling when the left upper sling unattached from the Hoyer, (resident) landing onto the floor. Her head hit the floor along with the left side of [his/her] body"....."resident was experiencing pain when moving the left leg, resident yelled out in pain." The resident suffered a non-displaced left femoral (hip) fracture as a result of the fall and subsequently died while on comfort measures on 3/26/18. Per review of the physician progress note dated 3/19/18, the resident 'has been in bed since the injury and nursing has been unable to move her	R126	See attached	

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R126	Continued From page 2 due to pain'. The family decided that Hospice care would be appropriate. Per interview with LNA #2 on 4/10/18 at 2:15 PM, the LNA stated that s/he had been employed at the facility for about 9 or 10 months and was a newly licensed LNA at the time of hire. She stated that she did have a competency on the use of a Hoyer as part of the LNA training course. When asked who trained h/her on use of the battery operated Hoyer lift, s/he stated that the LNA s/he was working with at the time of the accident (LNA #1) had oriented h/her upon hire to the job requirements, including proper use of the Hoyer. LNA #1 also confirmed that s/he had oriented LNA #2 to the Hoyer lift procedure. When the two LNAs involved in the accident were asked to demonstrate to the surveyor how they attached the fabric sling hooks to the Hoyer metal hooks on 3/15/18, neither one of them was able to demonstrate the correct application of the sling/pad hook. The demonstrations took place on 2 days, 4/9/18 and 4/10/18. LNA #2 also identified the wrong sling when s/he was asked to identify the sling used on the day of the accident for lifting Resident #1. Per interview (4/9/18 at 3:15 PM) with the Director of Nursing Services (DNS) who had begun her position at the facility 3 weeks prior to the accident, she stated that she was unable to find written demonstration of LNA competencies by the previous DNS as part of her investigation of the incident. She stated that all caregivers working there were LNAs. She confirmed that she did an immediate review with the 2 LNAs involved in the lift procedure the same day and had completed retraining on the use of the Hoyer lift for 2 additional LNAs also. She also stated that she delegated other facility RNs to assure that all	R126	see attached see attached	

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R126	Continued From page 3 LNAs providing care to the 3 residents who required use of the Hoyer at that time, had demonstrated competency prior to caring for these residents again. On 4/9/18, the DNS did confirm that when she returned to work after vacation, she discovered that not all LNAs had yet received retraining/demonstrated competency for the Hoyer procedure. When the surveyor was interviewing 2 evening shift LNAs (4/9/18 at 3:30) PM regarding any recent retraining on the Hoyer lift procedure since the accident on 3/15/18, both LNAs stated that they had not received any retraining on use of the Hoyer since the accident. They both confirmed that they had several years of experience with the use of multiple types of Hoyer lifts, and that they had been trained during their initial LNA licensure training, years previous to the present time. The DNS confirmed later that afternoon that she had not followed up to assure that all LNAs working in the facility (and could be required to float to both units) had demonstrated competency in use of the Hoyer lifts (the facility had 2 types of Hoyer lifts, mechanical and battery operated). The 2 staff on duty the evening of 4/9/18 did receive a competency evaluation prior to use of the Hoyer on that afternoon. Per interview with the 2 LNAs operating the Hoyer Lift for Resident #1 during the accident that occurred on 3/15/18 at approximately 10:30 AM, LNA #2 stated to the surveyor that resident was agitated and saying "Put me down, put me down" repeatedly, indicating her wish to be put back into the bed. The LNAs each said that this resident did not like to be lifted with the Hoyer and LNA #2 stated that she was not comfortable and confirmed that they did not respect the resident's right to be lowered back onto the bed. The LNA also confirmed that the resident's agitation in the	R126	See attached	

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R126	Continued From page 4 lift could be a safety issue and the process should have been discontinued when the resident objected. During interview regarding this violation of the resident's rights, the DNS confirmed that the LNAs should not have proceeded with the lift process after she had stated that she wanted to be 'put down...back in bed'.	R126		
R146 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the RN failed to assure that all direct care staff received instruction and supervision regarding each resident's health care needs and delegated nursing tasks as appropriate for 1 of 2 applicable residents in the targeted sample. (Resident #1). Findings include: Per observation of a demonstration of how to attach the fabric sling hoops to the metal hooks on the battery operated Hoyer lift on the morning of 4/11/18, LNAs #1 and #2 both failed to correctly secure the fabric sling hoops to the Hoyer lift hooks to assure a safe resident transfer. During an accident involving a Hoyer lift on 3/15/18 at 10.30 AM, one of the sling hoops detached from the Hoyer lift hook (supporting the upper body) during a transfer of Resident #1 from the bed to the wheelchair. The detachment	R146	See attached	

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R146	Continued From page 5 caused the resident to fall to the floor, sustaining serious injuries, including a left femoral fracture (hip) as well as bruising to the shoulder and knee areas, causing the resident significant ongoing daily pain. The resident died eleven days later, after being put on Hospice services and comfort measures. During interview with the DNS regarding training for the use of the Hoyer lift(s), she confirmed that there were no manuals or operational instructions to be found in the home for use by staff for training purposes. Additionally, two slings observed on 4/10/18 had the tags removed so it could not be determined what company had manufactured the slings to obtain specific information on the safe use of the equipment. Refer also to R126.	R146	See attached	
R173 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that all medications,	R173		

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R173	Continued From page 6 including biologics were stored in locked compartments at all times. This omission had the potential to affect wandering residents of the facility. Findings include: During a tour of the first floor resident unit on 4/9/18 during the afternoon, the nurse's station room was observed. The door was wide open to anyone wanting to enter and a unlocked closet was observed to have resident biologics/prescribed topical creams stored in drawers and used for treatment of various resident conditions. Also observed was an open bottle of sterile water, approximately 1/3 full, with no date when it was opened written on the bottle. The DNS who was present at the time of the observations confirmed that the closet should be kept locked and that the bottle of sterile water should have been labeled and dated when opened. The sterile water was disposed of after the observation. Refer also to R 222.	R173	Sl attached	
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation;	R179		

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R179	Continued From page 7 (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that all staff who provide direct care to residents demonstrated competency and received training in the 7 required trainings included in the Residential Care Home Licensing Regulations, dated effective on 10/03/2000. This failure was noted in training records for 6 of 7 staff training records reviewed. Findings include: Per review of the training records for 7 staff employed at the facility, only one of the 7 staff had completed all seven of the state mandated trainings at least annually and prior to working directly with residents. There was no documented evidence that the staff had demonstrated competency in the skills they were expected to perform before providing direct care to residents of the facility. This failure was confirmed with the Administrator on the afternoon of 4/10/18.	R179	SPE attached	

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R188	Continued From page 8	R188		
R188 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; physician's name, address and telephone number; instructions in case of resident's death; the resident's assessment(s); progress notes regarding any accident or incident and subsequent follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident's advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN/DNS failed to assure that facts related to an accident with resident injury were fully investigated and that investigation facts were documented for 1 applicable resident in the targeted sample. (Resident #1) Findings include: Per review of an event report related to a significant injury for Resident #1 on 3/15/18, the report was incompletely documented. Regarding the DNS' investigation of the event, she confirmed during interview on the afternoon of 4/9/18 that she had not documented all of her findings thus far and the surveyor requested that she provide a written summary of her investigation. Per review of the written summary	R188	Spe attached Spe attached Spe attached	

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R188	Continued From page 9 provided, the DNS listed 6 LNAs who had been deemed as competent by the RN. This included 2 LNAs interviewed by the surveyor on 4/10/18 at 3:40 PM, who were only deemed competent after they stated to the surveyor that they had not had any training on the use of the Hoyer thus far. The RN charge for the 3 - 11 shift later observed a Hoyer lift with these 2 LNAs and deemed them competent in the task. The DNS confirmed on 4/10/18 that all LNAs who work in the facility and may be required to use the Hoyer lift for a resident transfer (1 applicable resident at the time of survey), had not yet been deemed competent to safely use the Hoyer and she confirmed that only staff who have been deemed competent by demonstration with the RN will operate the Hoyers going forward. The DNS also confirmed that all LNA/staff trainings and investigations of accident/incidents will be documented and maintained for review by the survey agency. Refer also to R126.	R188	See attached	
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that there were written polices/procedures to govern all services provided by the home. This failure had the	R200	See attached	

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R200	Continued From page 10 potential to affect all residents of the facility. Findings include: 1. Per record review and a complaint received by the licensing agency, Resident #1 sustained significant injuries causing ongoing pain after falling from a Hoyer lift sling that detached from the Hoyer hook supporting the resident's left upper body. The resident fell on 3/15/28, landing on the left side and sustaining a left hip peri-prosthetic fracture, a skin tear on the left elbow and swollen right knee. During interviews with 4 LNAs during the survey, each stated that they had not received training by the RN on use of the Hoyer lift(s) prior to the accident. Per review of the facility's current Hoyer lift procedure with the DNS on the afternoon of 4/11/18, the written policy/procedure was not specific to the Hoyer lifts currently in use at the facility. Refer also to R 126. 2. Per observation and interview with the Food Service Director (FSD) on 4/9/18 at 10:45 AM, it was confirmed that the facility did not have current policies/procedures to address safe and sanitary food service protocols and dish machine operation. In addition, there were no written cleaning schedules for dietary staff to follow to assure a sanitary environment in all food preparation and storage areas. Observations of the walk-in cooler on 4/9/18 revealed unlabeled and undated perishable foods, which had the potential to adversely affect all residents of the home. One of the items on the cart of individual containers of foods left over from the salad bar the previous day had egg salad. None of the items were labeled and dated. When the FSD was asked if any of the foods were re-used on the salad bar after being out on the bar for a meal and then refrigerated, he stated that 'yes' they are	R200	see attached see attached	

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R200	Continued From page 11 put out on the bar again the following day. He stated that pickled vegetables may be re-used for up to a week. This practice is not in accordance with accepted safe food handling standards of practice, which excludes re-use of foods that have been out an a salad bar; foods left over from a salad bar have the potential to be contaminated and exposed to temperatures higher than 40 degrees Fahrenheit while out on the bar and should not be re-used. The FSD confirmed the lack of written food safety policies and procedures. 3. Per review of the temperature log for the automatic dish machine in the kitchen, rinse temperatures recorded included temperature lower than 180 degrees Fahrenheit. The FSD confirmed that the rinse cycle should be 180 degrees F. or higher to sanitize dishware. Three temperature during April included 173, 174 and 178. when the dish machine was run through the cycle, after 3 runs, the temperature still failed to meet 180 degrees F. the facility Maintenance Director had not been made aware of the below range rinse temperatures; subsequently he adjusted the hot water booster and the temperatures reached the 180 degree F. required to sanitize the dishware. The FSD confirmed that there was no policy/procedure related to use of the dish machine.	R200	See attached	
R222 SS=E	VI. RESIDENTS' RIGHTS 6.10 The resident's right to privacy extends to all records and personal information. Personal information about a resident shall not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts	R222	See attached	

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R222	Continued From page 12 from or information contained in such records shall be subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to protect the residents' right to privacy in all records and personal information at all times. This practice had the potential to affect all residents residing on the first floor unit. Findings include: During observations on the first floor resident unit on afternoon of 4/9//18, the nurses' station door was left wide open and no nursing staff were present in the room to oversee and protect resident medical records from access by unauthorized individuals. The surveyor stayed in the area to observe if any staff had left momentarily and returned, and no staff were visible on the wing, nor returned to the nursing station for several minutes. The DNS confirmed on 4/9/18 that the door should be locked when no nursing staff are present in the nursing station. Refer also to R 173.	R222	See attached	
R227 SS=G	VI. RESIDENTS' RIGHTS 6.15 Residents have the right to refuse care to the extent allowed by law. This includes the right to discharge himself or herself from the home. The home must fully inform the resident of the consequences of refusing care. If the resident	R227	See attached	

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OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R227	Continued From page 13 makes a fully informed decision to refuse care, the home must respect that decision and is absolved of further responsibility. If the refusal of care will result in a resident's needs increasing beyond what the home is licensed to provide, or will result in the home being in violation of these regulations, the home may issue the resident a thirty (30) day notice of discharge in accordance with section 5.3.a of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, staff failed to adhere to the resident's right to refuse care for 1 applicable resident in the targeted sample. (Resident #1). Findings include: Per interview with the 2 LNAs who were providing care to Resident #1 during a Hoyer lift transfer on 3/15/18, each LNA confirmed that the resident was protesting being in the Hoyer lift sling, up in the air; the resident stated repeatedly to the 2 LNAs "Put me down! Put me down!". On 4/10/18 at 2:15 PM, when asked if it was the resident's right to refuse the lift procedure, LNA #2 stated that 'yes, it was h/her right' to refuse. The LNAs did not stop the lift procedure and one loop that supported the left upper body of the resident became detached from the Hoyer lift and the resident fell to the floor, injury the left side of their body. The injuries sustained included a non-displaced left hip peri-prosthetic fracture. When the LNA was asked if s/he had told the DNS about the resident protesting the lift procedure, s/he stated the she had not. During interview with the DNS later the same afternoon, she confirmed that the LNAs should not have continued the lift procedure against the resident's wishes on 3/15/18.	R227	SLI attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R227	Continued From page 14 Refer also to R 126.	R227		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to assure that all perishable foods were labeled, dated and held at proper temperatures: At or below 40 degrees Fahrenheit, and at or above 140 degrees when served or heated prior to service. This practice had the potential to affect all residents of the facility. Findings include: Per observations in the facility kitchen on 4/9/18 commencing at 10:15 AM, the following foods were observed in the walk-in cooler: a cart had numerous perishable foods in stainless steel containers that had been on the salad bar the previous day, per the FSD (Food Service Director). None of the containers were labeled and dated with the date of preparation. Included were potentially hazardous foods including house prepared egg salad and grated cheeses, and cut up fresh vegetables. Also observed were undated and unlabeled containers with tartar sauce, sour cream and an unidentified item. When the FSD was asked for copies of the policy/procedure for food dating, he stated that he did not have any	R247	See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R247	Continued From page 15 policy to address the process for dating of perishable foods. The FSD confirmed that all perishable foods should be labeled and dated.	R247		
R249 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to assure that food handling and storage techniques were consistent with safe food handling practices. This practice had the potential to affect all residents of the facility. Findings include: Per observations in the facility kitchen on 4/9/18 commencing at 10:15 AM, the following foods were observed in the walk-in cooler: a cart had numerous perishable foods in stainless steel containers that had been on the salad bar the previous day, per the FSD (Food Service Director). None of the containers were labeled and dated with the date of preparation. Included were potentially hazardous foods including house prepared egg salad and grated cheeses, and cut up fresh vegetables. When asked if the left over foods from previous day were used again on the salad bar the next day, the FSD stated 'yes', he stated that some foods may used for up to a week on the salad bar. This practice is not in accordance with accepted safe food handling practices. It is not safe to re-use foods that have	R249	See Attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R249	Continued From page 16 been on a salad bar due to the potential contamination of foods during self-service and the lack of monitoring. There was also no process to assure the chilled foods remained in the safe temperature range (at or below 41 degrees Fahrenheit) while out on the salad bar.	R249		
R252 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Storage and Equipment 7.3.b Areas of the home used for storage of food, drink, equipment or utensils shall be constructed to be easily cleaned and shall be kept clean This REQUIREMENT is not met as evidenced by: Based on observation, areas in or near the kitchen used for storage of food, drink, utensils and equipment were not clean. This practice had the potential to affect all residents of the facility. Findings include: Per observation of the kitchen and food storage areas on 4/9/18 at 10:15 AM, the following areas were not clean: 1. The top surface of a hot water heater next to storage cabinets in the kitchen had dusty tools and items on the top and visible top surfaces had a layer a dust; 2. The storage cabinets were visibly soiled on the outside and interior doors and shelving; 3. A large metal meat tenderizer, (not in use per the FSD) was dusty; 4. A toaster observed on a tray with a crumbling cork bottom, was heavily soiled with food crumbs; 5. The gas grill was soiled with a build up of	R252	See attached	

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R252	Continued From page 17 grease around the frame and sides and under shelves; 6. The food storage room had a compressor for the walk-in cooler and a sump pump located in a corner; the equipment was heavily soiled with a build-up of dust, a table with non-dietary tools on top was visibly soiled; 7. The door to the food storage room had a metal vent area which was soiled with an accumulation of dust; 8. The fan cover on the cooling unit for the walk-in cooler was covered with dust; The FSD confirmed that there was no written cleaning schedule to assure that all areas for food preparation and food storage were maintained in a sanitary manner. The FSD accompanied the surveyor on the tour and confirmed the above observations.	R252		
R266 SS=E	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the home failed to assure that all areas of the home accessible to residents were free of potential safety concerns. This safety hazard had the potential to affect ambulatory residents of the home with cognitive impairment. Findings include:	R266	See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R266	Continued From page 18 During observations of the self service buffet area in the main dining room on 4/9/18 during the noon meal, an electric stove was observed on one wall near the buffet tables. When asked if there was a safety switch to prevent the stove from being operated by unauthorized persons, the FSD confirmed that there was no way at the present time to operate an off switch to disable operation of the stove. The FSD confirmed that residents may access this area when there are no staff in the room, presenting a safety hazard.	R266		

Our Lady of Providence response to the State regarding Survey and Investigational Review of April 2018:

R126 V. Resident Care and Home Services.

The plan for addressing the deficiencies as stated in 5.5 General Care 5.5a are as follows:

All LNAs and PCAs will be required to review and demonstrate competency in the performance of all skills necessary for the provision of safe care.

The general care staff licensed nursing assistants and resident assistants (LNAs & RAs) will not be allowed to provide resident care in instances where skilled care is necessary until the employee has been deemed competent. Typical skills that require competence include (are not limited to): hoyer lift use, one and two-person transfers, bath chair/scale use, whirlpool tubs use and maintenance, the application of compression stockings/circulatory aids, appropriate use of the rollator walkers, assisting with PROM, and obtaining vital signs. Other skills may be added to this list as residents come into the facility and age in place.

Working with the Director of Health Services, the nursing staff will be responsible for ensuring care giver staff have the appropriate skills needed to provide care on the units as assigned.

Each competency will be reviewed and demonstrated to the care staff by one of the nurses on staff. That nurse will observe the care staff demonstration and determine competence. The nurse will be responsible for providing immediate remediation at the time of the session as needed. The remediation will be clearly documented and placed in the care staff personnel file. (start 4/12/2018)

All staff hired as of 5/1/2018 will be deemed competent in the administration of all basic skills (as stated above) within 30 days of hire. Staff members who are currently employed will be given time off the floor to complete the competencies by 7/12/2018 (start 4/12/2018 hoyer training, bath tub use and disinfection, vital signs measurement)

There will be written instructions and a demonstration of each skill requiring competency determination. The care giver will complete a return demonstration of each skill with 100% accuracy in order to provide that specific care to any resident.

All competency checks will be reviewed with the Health Services Director and will be maintained in the employee file and shared with the staff nurses so that everyone is aware of the skills of each employee. Assignments will be delegated based on skills checks and competency.

Systemic changes to be made include:

Nurses to document staff competence and remediation as needed and completed.

A designated staff member will be assigned the task of monitoring and managing the staff skills and training schedule. That individual will meet with the Director of Health Services monthly to review each staff person's compliance rate. (start 7/1/2018)

R-126 POC accepted 5/17/18 M. Bolton, RN / S. Perry RN

R146 V. Resident Care and Home Services.

The plan for addressing the deficiencies as stated in 5.9 General Care, 5.9c is as follows:

This deficiency will be corrected through the process put into place as outlined in corrective action for R126. All nursing staff will be required to review the Hoyer use and instruction book which will be kept in each nurses' office. The nurses will be expected to ensure delegation of Hoyer lifting/transfers only to the staff who have been deemed competent in its use.

The appropriate sling for use with the Hoyer has been ordered and staff have been educated about not cutting tags or removing any type of informational label on the sling. The information that arrives with the sling will be made available for all to review and document they have read and understand how to use it. (sling to arrive in house ~5/15/18).

All nursing staff will be required to review the Tub and Chair instruction book. A copy of the book will be kept in each nurses' station and a copy will available for quick reference in each tub room. The nurse on duty will ensure delegation of use of the tubs and chairs only to the staff who have been deemed competent in its use.

Systemic changes to be made include:

Nurses to document staff competence and remediation as needed and completed.

A designated staff member will be assigned the task of monitoring and managing the staff skills and training schedule. That individual will meet with the Director of Health Services monthly to review each staff person's compliance rate. (start 7/1/2018) R146 POC accepted 5/17/18 M. Bolton RN/ S. Lewyer

R173 V. Resident Care and Home Services

The plan for addressing the deficiencies as stated in 5.10 Medication Management, 5.10h is as follows:

All nursing staff and care staff have been made aware that the door to the nurses' offices must be closed and locked at all times when there is no person occupying the office.

The nurse on duty and care staff assigned to the floor for the shift will have a key to access the main door to the office. (4/12/2018)

All biologics and prescription treatments and ointments will be locked in the cupboard in the nurses' office at all times. The various treatments will be organized according to resident and use. All open bottles/containers will be clearly labeled with the appropriate expiration date. All substances will be disposed of as per facility protocol based on the expiration date (started 4/12/2018)

Systemic changes to be made include:

Ongoing reinforcement of the need for the office treatment cupboards and the nurses' office to be locked at all times when no one is occupying the space. Appropriate signage has been printed and hung as reminders along with ongoing positive reinforcement for compliance. This is a behavior that all care

staff will have to change, and it should quickly become second nature with ongoing reminders and support (4/12/2018).

Monthly audits of all medications kept in the cupboards of the nurses' offices will be made by the Director of Health Services to ensure compliance. When errors are identified the entire nurse team (including med passers) will receive remediation as a group and an expectation of compliance will be reinforced. (Audit due 6/12/2018). R 173 POC accepted 5/17/18 M. Bolton RN/ Sleuyer RD

V. Resident Care and Home Services

The plan for addressing the deficiencies as stated in 5.11 Staff Services, 5.11b is as follows:

All new and current staff are required to complete 12 hours of mandatory training annually. Currently the training is a mixture of online resources (RELIAS) and in person lecture, demonstration and quizzes. All staff will complete RELIAS training modules as an introductory session to the topic identified and attend all required in house trainings to reinforce or introduce new material within the educational

All new staff will complete the 12 hours of RELIAS training during orientation (the first 30 days of employment) and current staff will be taken off the floor to complete the RELIAS modules as assigned by 7/1/2018.

Current facility staff (as of 4/17/2018) have completed two hours of training in 2018-*Resident Rights; Respectful and Effective Interaction with Residents.*

The remaining trainings are scheduled between May 30 and August 14, 2018 and include: Mandatory Reporting and General Supervision and Care (5/30/2018); Infection Control (6/19/2018); Emergency Response Procedures including Heimlich maneuver, accidents and first aid (7/10/2018); Fire Safety and Emergency Evacuation (8/30/18). Staff will receive mentoring, on the job training and discussion about these topics on a daily basis as they go through the work presented.

Additional training beyond the 7 mandatory trainings will include topics such as Caring for Residents with Dementia, End of Life Care, HIPPA, and other pertinent topics as identified by staff and residents. There will be a total of 12 hours of training documented for every care giver providing personal assistance to the residents.

Systemic changes to be made include:

Training schedules are posted for the year in an effort to support staff planning and promote attendance. (Mandatory Reporting and General Supervision and Care (5/30/2018); Infection Control (6/19/2018); Emergency Response Procedures including Heimlich maneuver, accidents and first aid (7/10/2018); Fire Safety and Emergency Evacuation (8/30/18).

Online training through the RELIAS program will be offered at work and staff may opt to complete assignments at home and be reimbursed for the time spent completing the module. All staff will be held

accountable for completing the assignments. If not completed staff will be removed from their care giving assignments until the required training is complete (starting 7/1/2018)

A designated staff member will be assigned the task of monitoring and managing the staff and training schedule. That individual will meet with the Director of Health Services monthly to review each staff person's compliance rate and design a plan for compliance as needed (start 7/1/2018).

R179 POC accepted 5/17/18 M. Bolton RN S Perry RN

V. Resident Care and Home Services

The plan for addressing the deficiencies as stated in 5.2.b(2) Staff Services, 5.11b is as follows:

The Health Services Team is currently working to develop a more comprehensive and user friendly in-house incident report that will support a stronger investigation of each incident. The newly revised incident report will capture all of the elements necessary to complete a comprehensive and accurate report of any incident (to be completed by 7/1/2018).

All nursing staff have been educated about the need for accurate and concise information to be documented on the incident report. The Director of Health Services is reviewing most reports in a timely manner and reinforcing follow up and assessment when needed based on the incident.

A skills check list for documenting staff competency in using the Hoyer lift has been implemented (start 4/12/2018). The skills check goes step by step through the process of getting a resident out of bed to the wheelchair as well as transferring the resident from the wheel chair to the bed. Nurses are using the document which supports consistency in training and documenting skill sets.

Systematic changes to be made include:

Finalizing and implementing a comprehensive incident report and documentation in the nursing notes (7/1/ 2018).

Ongoing monitoring and follow up of all incident reports submitted to the Director of Health Services to ensure completeness and safety for the resident. The Director will randomly select one incident report per month and complete a comprehensive review to ensure all documentation and follow up is complete (start 7/1/2018).

Ongoing training of the Hoyer use as well as other skills that are deemed necessary for the care givers to have. There is a checklist being developed for each skill and all will be complete ready for nurses to use by 7/30/2018.

R188 POC accepted 5/17/18 M. Bolton RN / S. Perry RN

VI. Resident Rights

The plan for addressing the deficiencies as stated in 6.10 is as follows:

All nursing staff and care staff have been made aware that the door to the nurses' office must be closed and locked at all times when there is no person in the office. This change in practice will ensure that

there is no opportunity for an unauthorized person to access and read any of the resident medical record files.

The nurse on duty and care staff assigned to the floor for the shift will have a key to access the main door to the office (4/12/2018)

Systemic changes to be made include:

Ongoing reinforcement of the need for the office treatment cupboards and the nurses' office to be locked at all times when no one is occupying the space. Appropriate signage has been printed and hung as reminders along with ongoing positive reinforcement for compliance. This is a behavior that all care staff will have to change, and it should quickly become second nature with ongoing reminders and support (started 4/12/2018). R222 POC accepted 5/17/18 M. Bolton RN / S. Perry RN

VI. Resident Rights

The plan for addressing the deficiencies as stated in 6.15 is as follows:

All staff who were employed as of 4/17/2018 attended a training about Resident's Rights. The training reinforced to staff is when a resident says "no", that means one does not continue on with the action in motion. Care givers are to report any refusal of care or treatment to the nurse on duty. The nurse will document all refusals of care and report to the Director of Health Services and physician as appropriate. All staff hired after 4/17/2018 will complete the RELIAS module addressing this topic within the first 45 days of employment (7/1/2018).

All care giving staff will be required to attend trainings (RELIAS) that address residents who refuse care and can be difficult to redirect (7/1/2018)

Nurses are charged with being strong mentors and support staff in managing residents with difficult behaviors. Nurses and seasoned staff are encouraged to talk with staff and residents whenever there is a refusal of care or treatment. Nurses are directed to document any refusal of care, treatments or medication in an effort to determine if it is a trend in behavior or perhaps a change in disease status.

Systemic changes to be made include:

Online training through the RELIAS program will be offered at work and staff may opt to complete assignments at home and be reimbursed (7/1/2018).

All staff will be held accountable for completing the assignment around how to work with difficult residents. If not completed staff will be removed from the schedule until the required training is complete (7/1/2018)

A designated staff member will be assigned the task of monitoring and managing the staff and training schedule. That individual will meet with the Director of Health Services monthly to review each staff person's compliance rate (7/1/2018).

POC R227 accepted 5/17/18 M. Bolton RN / S. Perry RN

Plan of Correction – Food Services April 27, 2018

Action Taken

Measures put in place

Monitoring procedures

Date corrective action will be completed

R200 V. Resident Care And Home Services

5.15 Policies and Procedures

A Food Services Policies and Procedures manual is currently available which addresses safe and sanitary food service protocols.

R200 #2:

Existing Policies and Procedures manual currently reflects washing and sanitizing dishes/utensils to include proper dishwasher operation and maintenance

The current Master Cleaning Schedule is being updated to include new equipment and procedures.

The Food Service Director (FSD) will supervise daily cleaning routines; check cleaning tasks against the master cleaning schedule daily; make updates to master cleaning schedule as needed for any changes in equipment or procedures; gather input from staff on the program.

The Updated Master Cleaning Schedule will be available June 1, 2018

#2 continued:

The Food Services Policies and Procedures Manual is currently being updated with policies and procedures related to the salad bar, this includes but is not limited to preparation, labeling, dating, monitoring, storage and re-service.

Currently salad bar items open to self-service are prepared fresh each meal.

A complete clean –out of stored perishable foods was conducted. Currently all perishable stored foods are labeled with item description, storage date and discard date.

Storage procedures including but not limited to dating and labeling are includes in the Food Services Policies and Procedures Manual.

FSD will monitor storage procedures daily.

The update to the Food Services Policies and Procedures Manual will be available June 1, 2018

R200 #3

Working with the Maintenance Supervisor, the thermostat on the hot water booster was increased slightly to ensure the final rinse temperature was consistently over 180 degrees F.

Currently, the Food Services Policies and Procedures Manual provides guidance on washing and sanitizing. The manual will be updated to include recording wash/rinse temperatures and policies and procedures if these critical limits are not met.

Training for all kitchen staff will be conducted on a regular basis on proper use of the dish machine.

The update to the Food Services Policies and Procedures Manual will be available June 1, 2018

R 200 POC accepted 5/17/18 M. Bolton, RN | S. Perry, RD

R247 VII. Nutrition and Food Services

7.2 Food Safety and Sanitation

A complete clean –out of stored perishable foods was conducted. Currently all perishable stored foods are labeled with item description, storage date and discard date.

Currently the Foodservices Policies and Procedures Manual contains guidance on labeling and storage

Training for all kitchen staff will be conducted on a regular basis on proper labeling of perishable foods. Records of this training will be maintained and available upon request.

R 247 POC accepted 5/17/18 M. Bolton RN/S. Perry, RD

R249 VII. Nutrition and Food Services

7.2 Food Safety and Sanitation

The Food Services Policies and Procedures Manual is currently being updated with policies and procedures related to the salad bar, this includes but is not limited to preparation, labeling, dating, monitoring, storage and re-service.

Currently salad bar items open to self-service are prepared fresh each meal.

Prepared salads, such as egg salad will be dated and stored at proper temperatures for no more than 3 days. Smaller portions will be removed from the larger batch, used at each mealtime then discarded.

Training from the FSD on proper procedures for the salad bar service will be conducted for kitchen staff, and records maintained.

FSD will ensure that fresh items are served on the salad bar each meal.

The policies listed above are currently in place.

R 249 POC accepted 5/17/18 M. Bolton RN/S. Perry, RD

R252 VII. Nutrition and Food Services

7.2 Food Storage and Equipment

The listed items (1-8) as noted on this survey were immediately taken care of. Cleaned. The Meat tenderizer has been covered due to it's infrequent use. After being cleaned, the compressor in the dry storage room has been partitioned off from the food storage.

The current Master Cleaning Schedule is being updated to include new equipment and procedures. This includes daily, weekly, monthly and annual tasks.

The Food Service Director (FSD) will supervise daily cleaning routines; check cleaning tasks against the master cleaning schedule daily; make updates to master cleaning schedule as needed for any changes in equipment or procedures; gather input from staff on the program.

The Updated Master Cleaning Schedule will be available June 1, 2018

R252 POC accepted 5/17/18 M. Bolton, RN/S. Perry RD

Division of Licensing and Protection

Response to State Survey of April 11, 2018

Provider:
Our Lady of Providence
47 West Spring Street
Winooski, VT 05404

IX. PHYSICAL PLANT

The plan for addressing 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment:

The Facility Director will have a safety switch installed to the electric stove in the dining area to prevent the stove from being operated by unauthorized persons.

The anticipated completion of this item is June, 2018.

R-266 POC accepted 5/17/18 M. Bolton RN S. Berry RN

Best Regards,

Brenda Schill
Administrator
Our Lady of Providence